Health Care
Innovation Initiative

Patient Centered Medical Homes (PCMH)
Technical Advisory Group (TAG) Recommendations and Program Information

PCMH program information

- A Sources of value
- B Care delivery model
- C Patient engagement
- D Eligibility requirements
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A PCMH sources of value

Sources of value

- **Appropriateness of care setting and forms of delivery** (e.g., increase in PCP visit to reduce ED utilization for medical conditions)
- **Increased access to care** (e.g., open office hours, open scheduling for walk-in appointments, and after-hours availability)
- **Improved treatment adherence** (e.g., adherence to mood stabilizer regimen, adherence to scheduled PCP visits)
- **Medication reconciliation**
- **Appropriateness of treatment**
- **Enhanced chronic condition management** (e.g., more frequent monitoring of A1c for diabetics)
- **Referrals to high-value medical and behavioral health care providers**
- **Reduced readmissions** through effective follow-up and transition management

B PCMH care delivery improvement model

	Stage 1: Providers in transition	Stage 2: Emerging model	Stage 3: Steady-state transformation
Primary patient prioritization	• All patients in PCMH • Primary PCMH prioritization[1] and focus on patients with **chronic conditions and existing PCP contact** due to near-term value capture	• Additional prioritization and focus on patient groups including: ▫ **Chronic conditions but no PCP contact[2]** ▫ **Patients at risk** of developing chronic condition	• **Broader focus on all patients** including healthy individuals
Focus for care delivery improvements	• Changes in **direct control of PCP** including ▫ Enhance access and continuity (e.g., office-hours, after-hours access) ▫ Provide self-care support and community resources including wraparound support ▫ Plan and manage care by developing evidence-based care plan with input from patient and their family ▫ Refer to high-value providers • Greater emphasis on **diagnosis and treatment of low-acuity behavioral health needs** • **Measure and improve performance**	Additional priorities to include: • Practice at **top of license** including use of extenders • **Joint decision-making with behavioral health providers** and other specialist • Improve integrity of **care transitions** • Address **social determinants of health**	Additional priorities to include: • **Multi-disciplinary team-based care** including regular interactions in-person • **Full IT connectivity across providers** including interoperable records • **Co-location of behavioral and physical healthcare** where feasible • **Health and wellness screenings, outreach, and engagement**

1 Prioritization of patient sub-groups to be conducted through the selection of quality and utilization measures, types of practice transformation support, allocation of staff resources for tracking and monitoring, and reporting focus 2 Based on claims

C TAG recommendations on patient engagement

	Recommendation	Examples
Educate patients	• Orient patients on PCMH program • Teach patients how to stay engaged in one's own health • Educate patients on options in their own care to increase patient autonomy • Create expectation for patients that their first visit is about getting to know PCP	• Play "Welcome to Medicaid" videos and other interactive modules in clinic lobby, similar to Medicare introductory materials • Provide patients with toolkit covering key topics associated with one's own care, e.g.: "How to keep track of your medicine" • Give patients plastic cards that say, "Stop! Before you go to the ER call this number", which leads to a staff nurse line • Provide patients with an actionable menu of options in care planning • Build in more time during initial patient visit to 'get to know' patient
Eliminate barriers to care	• Actively address social determinants of health (e.g., food, employment, transportation, family) • Utilize existing tools to screen for social determinants of health in pediatrics • Engage/connect with high needs behavioral health members in Health Homes	• Build formal relationships with local social service agencies (e.g., through care coordinators) • Transportation carriers in Memphis already offer reimbursement to those in need • Establish partnerships with legal entities to provide legal aid
Incentivize patients to engage	• Allow formal incentives for patients to engage in their own care (if feasible)	• Offer a gift card for each appointment attended on schedule and on time

D PCMH provider eligibility requirements

Commitment	• Stated commitment to the program
Minimum panel size	• Requirement of 500 patients with a single MCO to enter program
Practice type	• Eligible primary care TennCare practice type (i.e., family practice, general practice, pediatrics, internal medicine, geriatrics, FQHC, local health department) with one or more PCPs (including nurse practitioners)
Personnel	• Designation of PCMH Director
Activities	• Commit to PCMH activity requirements (see next page)

E PCMH provider activity requirements

Training	• All practices will have access to 2 years of practice transformation training and support through the State's provider training vendor. • Practices are required to participate in trainings, including learning collaboratives and conferences
NCQA Accreditation	• Maintain Level 2 or 3 PCMH accreditation from the National Committee for Quality Assurance (NCQA) ***OR*** • Meet Tennessee's specific activity requirements and begin working towards meeting NCQA's 2017[1] PCMH accreditation, once standards are finalized
Tools	• Commit to use of the state's shared Care Coordination Tool

[1]NCQA's 2017 recommended standards are expected to be finalized in March 2017. The recommended standards are available here: http://www.ncqa.org/Portals/0/PublicComment/PCMH%202017%20Recommendations%20Table.pdf?ver=2016-06-13-094129-053

E Tennessee specific activity requirements (1/4)

TAG RECOMMENDATION

Practices without NCQA level 2 or 3 accreditation will be expected to meet TAG recommended Tennessee specific activities that will prepare them for NCQA 2017 accreditation.

Standard	Elements with descriptions	Required factors
1 Patient-centered access	**Patient-centered appointment access (Element A)** The practice has a written process and defined standards for providing access to appointments, and regularly assesses its performance on the required factors	• Provide same-day appointments for routine and urgent care[1] • Provide routine and urgent care appointments outside regular business hours[1]
	24/7 Access to Clinical Advice (Element B) The practice has a written process and defined standards for providing access to clinical advice and continuity of medical record information at all times, and regularly assesses its performance on:	• Providing timely advice by telephone[1]
	Electronic Access (Element C) The following information and services are provided to patients/families/ caregivers, as specified, through a secure electronic system	• Clinical summaries are provided within 1 business day for more than 50% of office visits[1]
2 Team-based care	**The practice team (Element D)** The practice uses a team to provide a range of patient care services by:	• Defining roles for clinical and nonclinical team members[1] • Identifying team structure and the staff who lead and sustain team based care • Holding scheduled patient care team meetings or a structured communication process focused on individual patient care

Factors may be retired in NCQA 2017 standards

1 Recommended by TAG member

E Tennessee specific activity requirements (2/4)

TAG RECOMMENDATION

Practices without NCQA level 2 or 3 accreditation will be expected to meet TAG recommended Tennessee specific activities that will prepare them for NCQA 2017 accreditation.

Standard	Elements with descriptions	Required factors
3 Population health management	**Use data for population management (Element D)[1]** At least annually the practice proactively identifies populations of patients and reminds them, or their families / caregivers, of needed care based on patient information, clinical data, health assessments and evidence-based guidelines including:	• At least three different chronic or acute care services[1] • Patients not recently seen by the practice[1]
	Implement evidence-based decision support (Element E)[1] At least annually the practice proactively identifies populations of patients and reminds them, or their families / caregivers, of needed care based on patient information, clinical data, health assessments and evidence-based guidelines for:	• A mental health or substance use disorder[1] • A chronic medical condition[1] • An acute condition[1] • A condition related to unhealthy behaviors[1]

1 Recommended by TAG member

E Tennessee specific activity requirements (3/4)

Practices without NCQA level 2 or 3 accreditation will be expected to meet TAG recommended Tennessee specific activities that will prepare them for NCQA 2017 accreditation.

Standard	Elements with descriptions	Required factors
4 Care manage-ment support	**Identify patients for care management (Element A)** The practice [*shares a list developed through a systematic process as identified by the Care Coordination Tool of at least top 10% of patients*][1] who may benefit from care management. The process includes consideration of the following:	• Behavioral health conditions[2] • High cost/high utilization[2] • Poorly controlled / complex conditions • Social determinants of health[2] • Referrals by outside organizations
	Care planning and self-care support (Element B) The care team and patient / family / caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes the following features for 75% of all patients prioritized for care management [*i.e., top 10% of patients across various factors*][3]:	• Incorporates patient preferences and functional / lifestyle goals • Identifies treatment goals • Assesses and addresses potential barriers to meeting goals[2] • Includes a self-management plan[2] • Is provided in writing to the patient / family / caregiver[2]
	Use electronic prescribing (Element D) The practice uses an e-prescription system with one of the following capabilities[4]:	• More than 50% of eligible prescriptions written by the practice are compared to drug formularies and electronically sent to pharmacies • Performs patient-specific checks for drug-drug and drug-allergy interactions • Alerts prescribers to generic alternatives

Factors may be retired in NCQA 2017 standards

1 [Text] added to above NCQA Element A to specify target population as most high risk patients
2 Recommended by TAG member
3 [Text] is consistent with NCQA's intention to tie Element B with Element A above
4 NCQA does not specify "one of the following"; instead gives a higher score for meeting more factors

E Tennessee specific activity requirements (4/4)

Practices without NCQA level 2 or 3 accreditation will be expected to meet TAG recommended Tennessee specific activities that will prepare them for NCQA 2017 accreditation.

Standard	Elements with descriptions	Required factors
5 Care coordi-nation and care transit-ions	**Referral tracking and follow-up (Element B)** The practice will do the following:	❑ Track referrals until the consultant or specialist's report is available, flagging and following up on overdue reports[1]
	Coordinate care transitions (Element C) The practice will do the following:	❑ Consistently obtains patient discharge summaries from the hospital and other facilities[1] ❑ Proactively identifies patients with unplanned hospital admissions and emergency department visits[1] ❑ Proactively contacts patients/families for appropriate follow-up care within an appropriate period following a hospital admission or ED visit[1] ❑ Obtains proper consent for release of information and has a process for secure exchange of information and for coordination of care with community partners
6 Perform-ance measure-ment and quality improve-ment	The practice uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency, and patient experience[1]	No elements or factors required for this standard

TN

1 Recommended by TAG member

F TAG recommendation on training and practice transformation services

Initial assessment	• An initial, rapid, standardized assessment to develop a tailored curriculum for each site to establish baseline level of readiness for transformation • Focus of assessment to be strengths and gaps in workforce, infrastructure, and workflows as they relate to capabilities and transformation milestones, prioritizing areas for improvement
Practice transformation support curriculum	• Develop and execute a standard curriculum that can be tailored for each primary care practice site based on the needs identified in the pre-transformation assessment • Should cover 1st and 2nd years of transformation including frequency and structure of learning activities • Curriculum may include content structured through the following: – Learning collaboratives – Large format in-person trainings – Live webinars – Recorded trainings – On-site coaching
Semi-annual assessment	• Conduct assessments of progress toward each practice transformation milestone every 6 months; document progress

Important to account for differing needs across practice profiles (e.g., size, urban / rural)

F Training and practice transformation services

Practice transformation support curriculum

The PCMH curriculum will focus on building health care provider capabilities for effective patient population health management to **reduce the rate of growth** in total cost of care while **improving health, quality of care, and patient experience**.

This curriculum will include, but is not limited to, content in the following areas:

- Delivering integrated physical and behavioral health services;
- Team-based care and care coordination;
- Practice workflow redesign and management;
- Risk stratified and tailored care delivery;
- Enhanced patient access (e.g., flexible scheduling, expanded hours);
- Evidence-informed and shared decision making;
- Developing an integrated care plan;
- Patient and family engagement (e.g., motivational interviewing);
- Making meaningful use of Health Information Technology (HIT)/ Health Information Exchange (HIE);
- Making meaningful use of the care coordination tool (e.g., ADT feeds);
- Making meaningful use of provider reports;
- Business support; and
- Clinical workflow management

G TAG recommendation on provider reports

- **Practice Overview**
  - Basic information (e.g., attributed beneficiaries)
  - Required activity milestone completion
  - Practice support progress review (e.g., training milestones)
- **Quality performance report**
  - Progress against previous performance
  - Comparisons to peer organizations and national benchmarks
- **Total cost of care**
  - Progress against previous performance
  - Comparisons to peer organizations and national benchmarks
  - For large practices only: Shared savings due
- **Utilization performance report**
  - Progress against previous performance
  - Comparisons to peer organizations and national benchmarks

- Align reporting (e.g., format, style) as much as possible across MCOs
- Be transparent in the event of reporting errors

Quality Metrics for Pediatric Only and Adult Only PCMHs

Pediatric Practice Quality Metrics

1. **EPSDT screening rate (composite for older kids)**
   - Well-child visits ages 7-11 years
   - Adolescent well-care visits age 12-21
2. **Asthma medication management**
3. **Immunization composite metric**
   - Childhood immunizations
   - Immunizations for adolescents
4. **EPSDT screening rate (composite for younger kids)**
   - Well-child visits first 15 months
   - Well-child visits at 18, 24, & 30 months
   - Well-child visits ages 3-6 years
5. **Weight assessment and nutritional counseling**
   - BMI percentile
   - Counseling for nutrition

Adult Practice Quality Metrics

1. **Adult BMI screening**
2. **Antidepressant medication management**
3. **EPSDT: Adolescent well-care visits age 12-21**
4. **Comprehensive diabetes care (composite 1)**
   - Diabetes care: eye exam
   - Diabetes care: BP < 140/90
   - Diabetes care: nephropathy
5. **Comprehensive diabetes care (composite 2)**
   - Diabetes HbA1c testing
   - Diabetes HbA1c poor control (>9%)

Quality Metrics for Family Practices

Family Practice Quality Metrics

1	**Adult BMI screening**
2	**Antidepressant medication management**
3	**Comprehensive diabetes care (composite 1)**
	Diabetes eye exam
	Diabetes BP < 140/90
	Diabetes nephropathy
4	**Comprehensive diabetes care (composite 2)**
	Diabetes HbA1c testing
	Diabetes HbA1c poor control (> 9%)
5	**Asthma medication management**
6	**Immunization composite metric**
	Childhood immunizations
	Immunizations for adolescents
7	**EPSDT screening rate (Composite for youngest kids)**
	Well-child visits first 15 months
	Well-child visits at 18, 24, & 30 months
8	**EPSDT: Well-child visits ages 3-6 years**
9	**EPSDT Screening (Composite for older kids)** Well-child visits ages 7-11 years Adolescent well-care visits age 12-21
10	**Weight assessment and nutritional counseling** BMI percentile Counseling for nutrition